Department of Veterans Affairs Community Living Center Survey Report

This document or report and the information contained herein, which resulted from the Community Living Center Unannounced Survey, has been de-identified to remove individually identifiable health information (also known as protected health information) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other federal and state laws. De-Identification was completed in accordance with guidance published by the Office for Civil Rights to protect the privacy of the Community Living Center's residents.

General Information:

CLC: Edith Nourse Rogers Memorial Veterans Hospital (Bedford, MA)

Dates of Survey: 12/18/2018 to 12/20/2018

Total Available Beds: 240

Census on First Day of Survey: 228

F241

483.15(a) *Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not provide care and services for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect. Findings include:

Resident #204, [LOCATION]

- Resident #204 was admitted to the CLC with diagnoses including adjustment disorder with depressed mood and anxiety. According to the 30-day Minimum Data Set (MDS) dated 12/07/18, Resident #204 had clear speech, was understood by others and able to understand others, and had a score of 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition. The MDS was coded to indicate Resident #204 did not experience any signs or symptoms of delirium or behavioral symptoms of potential distress, and rejected care one to three days during the assessment period. According to the MDS, Resident #204 required physical help of one staff person during part of the bathing activity. During an interview on the morning of 12/20/18, a nurse manager stated Resident #204 currently showered independently.
- On 12/19/18 at 8:15 a.m., Resident #204 indicated that approximately two to three weeks ago, a registered nurse (RN) from another neighborhood and the nurse manager of the neighborhood in which the resident was residing attempted to take a wheelchair the resident was using because the wheelchair belonged to another resident; the staff entered the shared bathing room while Resident #204 was showering and according to the resident, both staff saw the resident without clothing. The resident explained that he left the shower curtain open approximately two feet because the resident did not like touching the shower curtain with his arm while showering. Resident #204 stated the nurse and nurse manager "walked right in without knocking." The resident referred to the staff by their first names, stating, "That wasn't right [for staff to enter the shower room without knocking]." Resident #204 reported the nurse took the wheelchair, leaving Resident #204 without a wheelchair while in the shower room. According to Resident #204, nursing staff in the neighborhood began looking for a replacement wheelchair; however, the resident used a regular chair (without wheels) to move back to his room, sitting in the chair and scooting along the floor and down the hallway. During the interview, Resident #204 reported to the surveyor that after the incident, his personal wheelchair was returned; Resident #204 was observed sitting in his personal wheelchair during the interview.
- The incident was documented in behavior incident and social work progress notes dated 11/26/18. The 11/26/18 social work progress note documented, "...Veteran said, 'What bothered me more was a woman walking into the shower'...he [the resident] felt [staff entering the shower room] violated abuse of power." According to the note the resident stated the registered nurse came to take the wheelchair that was in the shower room with the resident. The note read that the registered nurse "grabbed the wheelchair and said he was taking it now." The nurse manager then "walked right into the shower" stating that Resident #204 needs to "give him [the RN] the wheelchair, he is taking the wheelchair."
- On 12/19/18 at 11:40 a.m., the associate chief nurse stated she was familiar with the incident and that both nursing staff "were counseled" as the incident was "highly

inappropriate."

- On the morning of 12/18/18, during the initial tour, while passing the congregate shower room, the performance management specialist knocked on the shower room door; the nurse manager opened the door without first waiting for a response from anyone inside. There was one resident inside; however, the resident was clothed. Following the observation, several nursing staff were observed entering the shower room with residents in wheelchairs. The staff did not knock prior to entering the shower room.

F312

483.25(a)(3) *A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Some

Based on observation, interview and record review, the CLC did not ensure residents received necessary services to maintain good nutrition. Findings include:

Resident #406, [LOCATION]

- Resident #406's history and physical dated 06/07/18 indicated the resident had diagnoses including Parkinson's disease, dementia, dysphagia, and a stroke. The resident's quarterly MDS dated 11/28/18 indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment. The MDS indicated the resident required extensive assistance with eating and had no functional limitations in range of motion of the upper or lower extremities. According to the quarterly MDS, the resident weighed 178 pounds and had not experienced significant weight loss.
- During the initial tour of the [LOCATION] neighborhood, the charge nurse and clinical resource nurse said Resident #406 required "total care"
- Resident #406's care plan dated 06/07/18 stated, "My Concerns: Nutrition and weight status. My Goals: I want to have adequate intake/hydration (> [greater than] 75% meals/supplements) and tolerance to my diet consistency to maintain my skin integrity and preserve my lean body mass….How Can You Help Me: Continue Dysphagia Mechanically Altered diet…Continue Close supervision, 1:1 [one-to-one] feeding assistance as needed. Continue recommendations per SLP [speech language pathologist] Supervision/Assistance: Close supervision recommended, 1:1 feeding assistance only as needed. Precautions: Aspiration-please ensure veteran is OUT OF BED [emphasis not added] for all meals."
- A nutrition evaluation note dated 11/28/18 stated, "During visit to the unit [neighborhood] today he had eaten most of his lunch with nursing assistance - ~ [approximately] 75% of the meal. He requires assistance with his meals. Diet order Dysphagia mechanically altered diet (some advanced textures ok'd per SLP. Supplements Ensure at L/D [lunch/dinner]." The resident's nutrition diagnostic statement included the following:
    - Difficulty self-feeding related to advanced Alzheimer's disease as evidenced by need for 1:1 feeding assistance as needed and close supervision.
    - Close supervision recommended, 1:1 feeding assistance only as needed.
    - Precautions: ASPIRATION [emphasis not added]. Out of bed for meals.
    - Position upright.
    - Small sips small bites slow rate.
    - PRECAUTIONS: ASPIRATION [emphasis not added]."
- During observations in the dining room on 12/18/18, Resident #406 was sitting in a wheelchair and served the evening meal at 5:00 p.m. The resident sat at the table with a plate of food and two cups of liquid in small paper cups on the table in front of him. Initially, the resident started to drink Ensure® from one of the cups and then sat with his eyes closed. The resident opened his eyes at 5:15 p.m. when a staff person asked Resident #406 if he was going to eat. The resident started to eat, and reached for and spilled a cup of juice on the table; staff did not remove the spilled juice throughout the meal and did not replace the cup of juice. At 5:30 p.m., the resident remained at the table with his eyes closed occasionally taking a bite of food. Staff did not provide 1:1 assistance and close supervision of the resident during the meal observation. The resident had consumed approximately 25% of the meal when the observation concluded at 5:30 p.m. The associate chief nurse stated at the time of the meal service, "The dining room could use additional staff to assist residents."

Resident #407, [LOCATION]

- Resident #407 was admitted to the CLC with diagnoses that included dementia and Parkinson's disease. According to the resident's quarterly MDS dated 09/14/18, the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment. The quarterly MDS indicated Resident #407 experienced signs and symptoms of delirium including inattention, disorganized thinking and an altered level of consciousness that fluctuated. According to the quarterly MDS, the resident required extensive assistance for eating

and had functional limitations in range of motion of the bilateral upper and lower extremities. The MDS did not indicate the resident experienced a weight loss.
- During the initial tour on 12/18/18, the charge nurse and clinical resource nurse stated the resident required "total care" and had no significant weight loss.
- The resident's plan of care addressed the resident's nutrition status and weight maintenance and indicated the resident was to receive a regular diet. According to speech pathologist recommendations, the resident required the following:
    - "Supervision Level: Distant supervision:
    - Small sips, small bites, chew food thoroughly [at] slow rate, allow extra time between bites, sips for extra swallows.
    - Precautions: aspiration precautions, staff observe/feed patient if needed."
- A long-term care note dated 10/29/18 stated, "The resident was noted to be on a Regular diet and [experienced] Self-feeding difficulties related to dementia, Parkinson's disease evidenced by need for meal set up. Nutritional interventions continue to assist with meal set up."
- During observations on 12/18/18 at 4:45 p.m., Resident #407 was sitting at a dining room table with a plate of food and several small cups of liquid on the table; the meal consisted of turkey with vegetables. The turkey was cut into pieces and the resident used a fork to obtain pieces of turkey; approximately half of the turkey pieces were observed on the floor. During the meal observation, Resident #407 indicated he was unable to get the food from the plate to his mouth; staff did not assist the resident to eat during the meal observation.
- During the noon meal observation on 12/19/18 at 11:45 a.m., staff provided 1:1 assistance for the resident.

Resident #409, [LOCATION]

- Resident #409's history and physical dated 11/13/18 indicated the resident was admitted to the CLC on [DATE] with diagnoses including dementia and adult failure to thrive; the resident had a history of weight loss.
- The resident's most recent quarterly MDS dated 09/14/18 indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment. The MDS indicated the resident rejected care one to three days during the assessment period. According to the quarterly MDS, the resident required extensive assistance with eating and had no functional limitations in range of motion of the upper extremities. According to the 09/14/18 MDS, the resident had no weight loss.
- During the initial tour on 12/18/18, the charge nurse stated the resident was independent with activities of daily living with supervision and cueing required and had no "significant weight loss."
- The resident's plan of care dated 09/20/18 stated, "Nutrition and weight status. My goals: I want to prevent further weight loss and maintain my weight +/- [plus or minus] 2 lbs. [pounds] to promote my quality of life. Continue liberalized regular diet as tolerated….Continue to offer tray set up and assistance as needed, offer additional snacks and fluids in between meals and several times throughout the day as tolerated….Monitor weights weekly, last weight was 154 lbs. on 8/29/18 [prior to admission to the CLC]. Current diet regular amplified with whole milk and margarine. Ensure TID [three times a day], Sandwiches TID, chocolate milk at L/D magic cups at dinner. Offer increased assistance during meal times and feed Veteran if needed."
- Weight records indicated the resident weighed 138.5 pounds on 11/02/18 and 139.2 pounds on 12/09/18.
- During observations in the dining room on 12/18/18 at 4:45 p.m., Resident #409 was sitting at a table with a plate of food and several small cups of liquid in front of him; the plate included turkey with vegetables and mashed potatoes. The resident was observed getting up from the table with the plate of food, going to the trash bin to empty most of the food into the trash receptacle and placing the plate on a counter with other trays of food; the resident ate approximately 10% of the food. The resident returned to the table and drank 100% of the chocolate milk. The resident was observed getting up from the table multiple times to obtain more chocolate milk which the resident drank. The resident then returned to the plate that had been put on the counter and placed his fingers into what was left of the mashed potatoes; the resident ate the potatoes using his fingers. The resident left the dining room and returned on multiple occasions during the meal. Staff did not provide assistance or intervene during the meal observation to offer the resident another plate of food and encourage the resident to eat.

Resident #408, [LOCATION]

- According to the history and physical dated 07/26/18, Resident #408 was admitted to the CLC with diagnoses including dementia.
- The resident's most recent quarterly MDS dated 10/14/18 indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for

daily decision making based on staff assessment. The MDS indicated the resident had signs and symptoms of delirium including inattention and disorganized thinking that was consistently present. According to the quarterly MDS, the resident required extensive assistance with eating and had no functional limitations in range of motion of the upper extremities.

- During the initial tour on 12/18/18, the charge nurse stated the resident required extensive assistance with activities of daily living. Staff indicated the resident required extensive assistance with eating due to inattention and distraction. Staff reported the resident had not had a "significant weight loss."
- The resident's plan of care dated 08/08/18 stated, "Nutrition: My Concern: Nutrition and Weight Status. How You Can Help Me: Continue Regular diet as tolerated. Trial pro-stat [nutritional supplement] at lunch and Dinner for healing; Honor food preferences. Provide assistance with tray set-up and feeding as needed. Monitor tolerance to diet consistency."
- Documented weights reflected a 19.8-pound (7.9%) weight loss between 08/01/18 and 12/05/18 (4 months). The resident weighed 248.2 pounds on 08/01/18 and 228.4 pounds on 12/05/18.
- A nutrition evaluation note dated 11/28/18 stated, "1) Self feeding difficulties related to Alzheimer's dementia as evidenced by need for meal set up and assistance prn [as needed]. Encouragement needed during meals. Regular diet."
- During observations in the dining room on 12/18/18 at 5:05 p.m., Resident #408 was sitting in a wheelchair and served the evening meal. The resident sat at the table with a plate of food and two cups of liquid in small paper cups on the table in front of him. Initially, the resident was awake and ate several bites independently; after several bites, the resident sat with his eyes closed intermittently. At 5:30 p.m., the resident remained at the table with his eyes closed; occasionally, the resident would take a bite of food. At 5:30 p.m., the resident had consumed 25% of the meal. Staff did not provide assistance for the resident during the meal observation.

F314

483.25(c) *Pressure Sores. Based on the comprehensive Assessment of a resident, the facility must ensure that (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that a resident who entered the CLC without pressure ulcers did not develop pressure ulcers; and a resident having pressure ulcers received necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing. Findings include:

Resident #201, [LOCATION]

- According to records reviewed, Resident #201 was admitted to the CLC on [DATE] with diagnoses including a healing Stage 3 pressure ulcer, cerebrovascular accident (CVA), end stage renal disease (ESRD), and a right above knee amputation.
- The resident's admission MDS dated [DATE] was coded to indicate the resident was at risk for developing pressure ulcers with no pressure ulcers at the time of the assessment; skin and ulcer treatments included nutrition/hydration interventions and application of ointments/medications other than to the feet. The admission MDS was coded to indicate Resident #201 was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #201's most recent quarterly MDS dated 12/02/18 was coded to indicate the resident had clear speech, usually understood and was usually understood by others; the resident had short-term memory problems and moderately impaired cognitive skills for daily decision making based on staff assessment. The MDS was coded to indicate the resident required extensive assistance with activities of daily living (ADLs), had functional limitations in range of motion in both lower extremities and one upper extremity, and used a wheelchair for mobility. The MDS was coded to indicate Resident #201 was at risk for developing pressure ulcers; the resident had one Stage 1 and one Stage 3 pressure ulcer. The dimensions of the Stage 3 pressure ulcer were 0.2 cm [centimeters] in length by 0.2 cm in width by 0.1 cm in depth; there were no worsening pressure ulcers. Treatments included pressure reducing devices for both the bed and chair, a turning/repositioning program, nutrition/hydration interventions, application of nonsurgical dressings and application of ointments/medications other than to the feet. The quarterly MDS was coded to indicate Resident #201 was occasionally incontinent of bladder and bowel.
- During the initial tour on 12/18/18 at 10:30 a.m., an RN stated Resident #201 had a pressure ulcer over the sacrum that was healing; the pressure ulcer developed in the CLC. The registered nurse reported that Resident #201 required the use of a Hoyer lift for transfers, required assistance with repositioning, and received hemodialysis (off campus) three times a week for three to four hours at a time.
- Resident #201's treatment plan (care plan) dated 09/14/18 included the following statement, "I am at risk for skin breakdown due to periods of incontinence, restricted mobility d/t [due to] right hemiparesis and right AKA [above knee amputation]." The corresponding goal read, "I want my skin to remain clean, dry and intact…." Pertinent

approaches included keeping "skin clean and dry," using "protective barrier ointment as needed," providing a "urinal and bedpan for toileting at scheduled intervals because I spend most of my time in bed," and encouraging "small, frequent position changes in bed and electric wheelchair as needed[.] Please keep my HOB [head of bed] at or below 30 degrees when I am not eating."

- Resident #201 had the following current provider orders related to wound care:
    - 09/19/18 "Please obtain Versacare bed for Veteran to promote skin integrity…." (It was confirmed during observations during the survey that the resident had a Hill-Rom VersaCare® bed.)
    - 11/29/18: "Stage 3 HAPI [hospital acquired pressure injury] to the coccyx: cleanse wound bed with NS [normal saline], apply skin prep to periwound, apply small cut to fit piece of Promogran Prisma and place in wound bed, moisten with saline and cover with Mepilex border. Change every other day and prn [as needed]."
- A 10/02/18 occupational therapy note referenced Resident #201's power wheelchair seating and read, "[Resident #201] Reports buttocks continues to bother him from current power w/c [wheelchair]. OT [occupational therapy] will contact spouse on alternative w/c [wheelchair]."
- A 10/04/18 nursing note first identified Resident #201's pressure ulcer. The note read, "Veteran was noted to have new open area to sacrum. He c/o [complains of] discomfort to this area. Open area measures approx. [approximately] 0.5 cm x [by] 0.5 cm, has red border and yellow tissue noted covering entire wound. Surrounding skin is red but blanchable. Protective dressing applied. Encouraged Veteran to reposition self in bed every 2 hours and to ask for assistance when needed. Veteran is agreeable. He allowed this writer to reposition him @ [at] this time. Will notify wound nurse for assessment…."
- A 10/09/18 nursing note, authored by the wound care certified nurse (WCCN) stated, "Small opening at mid sacrum measuring approx. 0.7 cm x 0.5 cm x 0.1 cm[.] Periwound intact, no drainage noted, wound bed with 100% cream colored slough. Unstageable PI [pressure injury] to the sacrum. Recommend and applied cleanser with ns [normal saline], pat dry, apply no sting skin prep to periwound and wound edges. Applied firmly a regular hydrocolloid….Documentation from OT 10/2 [10/02/18] reflects the concern of power wheelchair causing an issue[.] Wife also spoke about the wheelchair being a problem. Educated the resident and wife about pressure injuries and prevention. Specialty bed arranged. Trial waffle cushion to place under buttocks on stretcher to dialysis and perhaps dialysis chair?? [*sic*] Cushion supplied to the unit." No documentation was provided indicating that additional consultation with physical or occupational therapy occurred to ensure the waffle cushion was the most appropriate pressure reducing device for the power chair and/or the recliner used at the dialysis center.
- A nursing skin assessment note dated 12/14/18 documented Resident #201 had a Braden Scale for Predicting Pressure Ulcer Risk score of 15 suggesting mild risk for skin breakdown.
- The most recent nursing note by the wound care certified nurse on 12/17/18 read, "Bedside to change the dressing to the stage 3 PI [pressure injury] to the sacrum. Explained to the resident the procedure. Small, round approx. 0.2 x 0.2 x < [less than] 0.1 cm open area persists. Scant serosang [serosanguinous] drainage on removed dressing. The wound bed is dry in appearance and ?? [questionable if] fibrotic vs. [versus] pink. May heal in a non traditional manner. Continue with the current treatment. Cleansed with ns, skin prep applied, saline moistened Promogran Prisma f/ [*sic*] mepilex border dressing applied."
- On 12/18/18 at 2:30 p.m., Resident #201 was observed lying in bed; the head of the bed was raised approximately 30 degrees. The resident reported spending most of the day in bed, especially after returning from dialysis. Resident #201 stated he sat in a recliner-type chair at the dialysis center that did not have any special (pressure reducing) cushion and that sitting on the chair "sometimes hurts [the resident's sacrum]." Resident #201 stated that he could bring a waffle cushion with him to dialysis; however, the resident was concerned the cushion would get lost; the waffle cushion was observed in the corner of the resident's room and appeared to be partially deflated.
- On 12/19/18 at 10:55 a.m., the charge nurse stated Resident #201 sat on a specialty cushion when sitting in the resident's electric wheelchair; however, the charge nurse was unsure if the resident sat on a specialty cushion while at dialysis.
- On 12/19/18 at 12:50 p.m., the WCCN reported that Resident #201 was provided with a waffle cushion to use while at dialysis and that the resident reported the cushion "helps."
- On 12/19/18 at 1:00 p.m., Resident #201's wound care was observed. The nurse removed the old dressing. A pin point healing Stage 3 pressure ulcer was observed over the resident's sacrum; the surrounding skin was blanchable. Resident #201 changed positions independently during the wound care observation. A waffle cushion

was observed on Resident #201's power wheelchair; the cushion was deflated and folded in the wheelchair.
- Following the wound care observation on 12/19/18 at 1:15 p.m., while discussing specialty cushions for pressure reduction for Resident #201, the WCCN stated her recommendation for Resident #201 would be to use a "ROHO cushion [rather than waffle cushion]."

Management of Pressure Reducing Devices

- During observations of the dining room in the [LOCATION] neighborhood on 12/19/18 at 11:45 a.m., 12 residents were sitting in wheelchairs with ROHO or other pressure reducing cushions including Resident #406 and Resident #407.
- Resident #406's MDS indicated the resident was at risk for pressure ulcer development. During the initial tour of the [LOCATION] neighborhood, the charge nurse and clinical resource nurse said Resident #406 required total care and had no skin issues including pressure ulcers. Resident #407's MDS indicated the resident was at risk for pressure ulcers and had one unhealed Stage 2 pressure ulcer. Skin and ulcer treatments included application of ointments/medications other than to feet and pressure reducing devices for the chair and bed. The resident's Stage 2 pressure ulcer had healed at the time of the survey.
- During an interview with the chief of rehabilitation on 12/19/18 at 11:00 a.m., the chief stated (pressure reducing) cushions were provided after the resident's need was determined and a consult was initiated with physical therapy. The chief of rehabilitation stated, "Daily care [of pressure reducing cushions] is up to nursing."
- On 12/19/18 at 12:20 p.m., a nurse manager stated occupational therapy provided pressure reducing cushions based on a provider's request. The nurse manager said nursing staff determined if the cushion was inflated correctly by "touch or sight."
- According to the ROHO DRY FLOATATION® Wheelchair Cushions Instruction & Safety Manual obtained online, ROHO, Inc. recommends that a clinician "CHECK INFLATION, FREQUENTLY, AT LEAST ONCE A DAY! PROPER INFLATION: [emphasis not added] The use of any other inflation device other than the supplied hand pump may damage the cushion and void the warranty…UNDER-INFLATION: DO NOT [emphasis not added] use an underinflated cushion. Doing so reduces or eliminates the cushion's benefits, increasing risk to the skin and other soft tissue. If your cushion appears under inflated or does not appear to be holding air, check to make sure that all valve(s) are closed by turning the inflation valve(s) clockwise….OVER-INFLATION: DO NOT [emphasis not added] use an over-inflated cushion. Doing so will not allow you to sink into the cushion and will reduce or eliminate the cushion's benefits increasing risk to the skin and other soft tissue."
- A policy and procedure for implementation and management of the ROHO and other pressure reducing cushions was requested from staff. Staff reported the CLC did not have a policy and procedure to direct management of the cushions; this information was confirmed by leadership staff during an interview on 12/20/18 at 11:30 a.m. when it was indicated the CLC and Veterans Integrated Service Network (VISN) did not have a policy for management of pressure reducing cushions. There was no documentation provided to indicate the frequency at which pressure reducing cushions were checked by staff.

F322

483.25(q)(2) *A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure a resident with a percutaneous endoscopic gastrostomy (PEG) tube received appropriate treatment and services. Findings include:

On 12/19/18 at 1:45 p.m., the associate director of patient care services provided Elsevier's Clinical Skill titled, "Feeding Tube: Medication Administration." The policy stated, "19. Prepare medications for instillation into the feeding tube….b. Tablet: Crush the tablet using a pill-crushing device to grind it into a fine powder. Mix and dilute it in at least 30 ml [milliliters] of purified or sterile water. For more than one tablet, crush and dilute each individually….23. Check the placement of the feeding tube….24. Check for gastric residual volume (GRV)….26 Draw 30 ml of purified or sterile water into a 30-ml or larger syringe, insert the tip of the syringe into the feeding tube, and flush the tube. 27. Administer liquid or dissolved medication by pouring it into the syringe. a. Following the administration of medications or formula, clear the tube by flushing with a minimum of 15 ml of purified or sterile water. b. If administering more than one medication, give each separately and flush between medications with at least 15 ml of purified or sterile water."

Resident #306, [LOCATION]

- On 12/19/18 at 8:12 a.m., a surveyor and performance management specialist observed an LPN administering six medications including two medications in liquid

form and four medication tablets for Resident #306 through the resident's PEG tube. The LPN did not check for placement or gastric residual volume (GRV) prior to administering the medications. The LPN flushed the PEG tube with 30 ml of sterile water prior to administering the first medication.
- Following the observation, the LPN was asked about checking for gastric residual volume prior to administering the medications. The LPN stated, "I usually don't check for gastric residual volume or placement prior to administering medications [through a feeding tube]."

F323

483.25(h)(1) *Accidents. The facility must ensure that: The resident environment remains as free of accident hazards as is possible;*

Level of Harm - Immediate jeopardy to resident health or safety

Resident Affected - Few

Based on observation, interview and record review, the CLC did not ensure the resident environment remained as free from accident hazards as is possible; and each resident received adequate supervision to prevent accidents. Findings include:

Smoking Safety:
The Medical Center Nursing Services Memorandum No. 17-05 dated January 10, 2018 and titled, "Assessment of Smoking Risk for Community Living Center Veterans" was provided by the chief of quality management on 12/18/18 at 5:33 p.m. The memorandum indicated, "Smoking is not permitted in the CLCs or anywhere in the building or on the grounds of the Edith Nourse Memorial Veterans Hospital, except in the designated smoking areas, and only if the Veteran [resident] has been assessed as able to smoke safely….Lighters and matches are banned from the CLCs. Mounted igniters are available in designated areas."
"3. Procedures….
- D. Veterans determined to be safe for independent smoking will be allowed to smoke in the designated smoking areas…This determination will be documented in their care plan, along with any required safety measures such as use of a smoking apron.
- E. Those not safe for independent smoking will have that documented in their care plan….
- K. If an appropriate health care professional assesses a Veteran to be a smoking hazard to him/her or others, either because of his/her physical, mental condition, this Veteran and/or Veteran will be classified as 'high risk.' A Veteran may also be classified as 'high risk' if he/she exhibits unsafe clinical behavioral traits involving smoking, such as:
  - 1. Attempting to hide his/her smoking materials or activities from staff.
  - 2. Having a history of non-compliance with smoking rules.
  - 3. Smoking in a Veteran sleeping room or other areas designated as non-smoking areas.
- L. The Veteran's treatment plan will be updated whenever there is a change in the Veteran's smoking assessment."

Resident #303, [LOCATION]

- Resident #303 was admitted to the CLC with diagnoses including dementia, diabetes, and neuropathy.
- Resident #303's annual history and physical dated 03/02/18 stated, "Mental status: Alert, oriented to himself. Education: Deferred due to impaired cognition….Dementia – Neuropsychology evaluation in April 2017 showed "limited understanding of his medical conditions and poor reasoning/judgement indicate limited capacity to make complex medical decisions."
- Resident #303's quarterly MDS dated 08/16/18 indicated the resident was understood by and understood others, and had long and short-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment. The MDS indicated the resident required limited supervision of staff with transfers; required extensive assistance of one staff person with dressing, toilet use and bathing; and had no functional limitations in range of motion. The quarterly MDS indicated Resident #303 rejected care 1 to 3 days during the assessment period. The resident's comprehensive MDS dated 11/08/18 indicated the resident was understood by and understood others, had long and short-term memory problems, and severely impaired cognitive skills for daily decision making based on staff assessment. The MDS indicated the resident required limited supervision by staff with transfers and personal hygiene; required extensive assistance of one staff person with dressing, toilet use and bathing; and had no functional limitations in range of motion. Behavioral symptoms included physical and verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others 1 to 3 days during the assessment period; the resident rejected care 4 to 6 days and wandered 1 to 3 days during the assessment period. The behavioral symptoms placed Resident #303 and others at significant risk for physical illness or injury, significantly interfered with Resident #303's care, and significantly disrupted care or the living environment. The comprehensive MDS indicated the resident used tobacco.

- Resident #303's care area assessment (CAA) dated 12/11/18 and completed in conjunction with the 11/08/18 MDS indicated the "resident is immediate threat to others – IMMEDIATE INTERVENTIONS REQUIRED [emphasis not added]. Veteran has had several behaviors in the look back period, wandering, pushing, verbally abusive to staff, refusing care, agitation, a STAR VA plan was initiated with veteran."
- During the initial tour on 12/18/18 at approximately 11:00 a.m., the charge registered nurse (RN) stated Resident #303 was a "smoker," utilized a WanderGuard® bracelet to alert staff of attempts to leave the neighborhood without an escort to smoke, wore a smoking apron due to staff finding a burn hole in his wheelchair cushion, had a dementia diagnosis, and staff monitored Resident #303 to ensure the resident wore a coat when going to the smoking shack. According to the charge RN, Resident #303 came to the nursing station when he wanted to go to the smoking shack and was provided two cigarettes and a lighter; the resident did not require supervision when smoking.
- Resident #303's mental health evaluation note (psychiatry consult) dated 07/12/18 indicated, "Vet [Veteran] is aggressive towards staff – refusing medication including psychiatric regime. His memory however was overall a very poor historian during today's interview. Insight/Judgement – Limited." The note did not address smoking.
- A provider's order dated 07/16/18 stated, "Please place Wanderguard on pt [patient]."
- Resident #303's monthly nursing note dated 08/25/18 stated, "Veteran goes off ward [neighborhood] to smoke with non-nursing staff with no incidents reported."
- Resident #303's quarterly social work progress note dated 08/24/18 read, "Veteran has the wanderguard and is taken down for cigarette breaks by volunteers. At times he is found on the elevator becoming agitated when staff have to get him out of the elevator. DX [diagnosis]: Dementia – Unspecified dementia without behavioral disturbance."
- The "Nursing: Smoking Risk Assessment" dated 10/09/18 indicated Resident #303 required supervision while smoking.
- The "Nursing: Smoking Risk Assessment" dated 10/31/18 was completed due to a significant change in the resident's condition and indicated Resident #303 required supervision while smoking. An addendum to the assessment stated, "Resident found to have some burn holes in some of his clothing and seat cushion of his wheelchair. There is no evidence of skin involvement as yet. Resident refuses to allow staff assessment of his skin at this time. Spouse informed of decision to suspend his smoking privileges at this time and she was agreeable with decision. Spouse also informed this writer that she had noticed the burn holes in his clothing and chair when she visited last. Resident outright refuses to wear smoking vest at this time."
- The CLC provided three behavioral incident notes related to smoking including the following:
    - 11/02/18 at 9:49 p.m., "Veteran instructed on change in smoke privileges – responded with 'I don't need to follow any rules.' Threatening anyone who attempts to stop him from doing as he wishes. Disrupting environment with elevator and wanderguard alarms continually going off and causing other residents to complain about the noise….Time of day behavior(s) occur: Whenever he wishes to go out to smoke….Describe the outcomes of the interventions: VA police needed to be called times 2 this evening. As soon as officer left resident returned to elevators and refused to be dislodged [removed from elevator]....Overall effectiveness of interventions: Disruptiveness stayed the same."
    - 11/03/18 at 9:12 p.m., "Refusing to follow smoking policy; refusing to leave elevator when trying to leave ward to smoke unsupervised; verbal threats directed towards anyone attempting to prevent his leaving ward unsupervised. Resident not willing to follow his current smoking privileges (supervision with smoking apron) stating, 'I don't follow any rules.'…Describe the outcome of the interventions: Resident was told the VA police would be called if he did not quit the abuse dialogue and threats. He left the area [and went] to his room."
    - 11/04/18 at 8:18 p.m., "Refusing to follow directions, agitation, physical threats. Describe Behaviors: Insistent with going off unit to smoke without staff and smoke apron. Refusing to leave elevator as it alarms and preventing others from using. Threatening staff with physical violence. Evening supervisor witnessed."
- Resident #303's nursing long term care note dated 11/07/18 stated, "Smoking: Veteran per ward [neighborhood] NP [nurse practitioner], can go off unit [neighborhood] to smoke with apron and one cigarette at a time. Veteran has been compliant and turning in his lighter upon return [to the neighborhood]." According to the associate chief nurse, this meant the resident could be provided with one cigarette and his lighter by nursing staff. He had to wear the smoking apron when leaving the neighborhood and did not require supervision to smoke.
- The "Nursing: Smoking Risk Assessment" dated 11/11/18 indicated Resident #303 required supervision while smoking.
- Resident #303's plan of care dated 11/13/18 stated, "Resident is now 1:1 [one-to-one] to go off unit [neighborhood] for smoking and any other reason. Residents wife will be

notified by manager of unit as well as social worker in regard to a trial of no 1:1 for smoking. Md [medical doctor] aware of this potential change." The care plan did not indicate the resident required a smoking apron and was provided one cigarette and a lighter by staff prior to leaving the CLC to smoke.

- Resident #303's monthly nursing note dated 11/14/18 stated, "Mood/Orientation /Behaviors: Appropriate, Anxious, Agitated, aggressive, Resistive to care, Verbally abusive, combative. Oriented to person, place. Barriers to learning present: Confused/memory problem. Risk Factors: Fall, Pain, Elopement, Assaultive: Yes. "Vet cont [continues] to utilize w/c [wheelchair] to self-propel I [independently] on and off the ward. Vet goes off ward to smoke with non-nursing staff with no incidents reported. Vet noted to be compliant (with reminders) to use of smoking apron/vest.
- The "Nursing: Smoking Risk Assessment" dated 12/04/18 indicated Resident #303 was not physically capable of holding a cigarette, matches or a lighter, and lighting and extinguishing his own cigarette; was not compliant with the smoking policy; had been found not to be alert while smoking; had a cognitive or physical limitation that limited the resident's ability to smoke safely; had a history of non-compliance with smoking safety rules; attempted to hide smoking activities or materials on three or more separate occasions; and did not wear a smoking apron as indicated. The assessment indicated Resident #303 was a "supervised smoker." Actions for supervised smokers according to the smoking risk assessment included, "Must be accompanied by staff, family, or trained volunteer to smoke…Veteran is found with smoking material when assessed to be unsafe to smoke unsupervised. NOT AT THIS TIME AS RESIDENT HAS ORDER TO GO SMOKING USING SMOKING VEST AND COME BACK IN TIME. [emphasis not added; no further clarification was provided regarding this statement]."
- On 12/18/18 at 2:10 p.m., Resident #303 was observed moving his wheelchair in the hallway to the elevator. A staff member informed Resident #303 he needed his smoking apron if he was going outside to smoke. Resident #303 went to his room and at 2:35 p.m. approached the nursing station desk while wearing the smoking apron. The resident asked for cigarettes and a lighter and staff provided Resident #303 with two cigarettes and a lighter. Resident #303 moved in his wheelchair to the elevator and the WanderGuard perimeter security system alarm sounded; a staff member turned off the WanderGuard alarm and assisted Resident #303 to enter the elevator by holding the door open. At 2:52 p.m., Resident #303 was observed exiting the CLC through the door (B-25) of the recreational therapy room in the basement level of the CLC; the resident was wearing the smoking apron, and carrying the lighter and two cigarettes. Resident #303 moved his wheelchair approximately four or five feet along the sidewalk and outside the door, and lit a cigarette. The associate director of patient care services (ADPCS) present during the observation, informed Resident #303 twice that he was not smoking in the designated area (smoking shack). Resident #303 cursed at the ADPCS and stated that he was not going to the smoking shack. The resident said that he could smoke wherever he wanted and did not have to listen to anyone and refused to relocate to the smoking shelter. The ADPCS reported the event to the CLC police and notified nursing staff in the [LOCATION] neighborhood.
- On 12/19/18 at 8:50 a.m., a different charge RN than the charge RN interviewed on 12/18/18 during the initial tour, was interviewed and stated Resident #303 wore a smoking apron when smoking due to burns found in his clothing which "happened more than once." The charge RN indicated Resident #303 kept the smoking apron in his room and came to the nursing station to request his cigarettes when he wanted to smoke; when requested, nurses provided two cigarettes and a lighter. Resident #303 transported himself to the smoke shack and smoked independently without supervision. The charge RN stated, "This morning he asked for his cigarettes and I had to tell him his smoking privileges had been revoked yesterday [12/18/18] due to him smoking in an unauthorized area….It did not seem [Resident #303] actually registered what I told him. He did not say anything else, just sat in his wheelchair." The RN stated she did not know how it was determined Resident #303 was safe to smoke unsupervised at the current time.
- On 12/19/18 at 9:00 a.m., a nursing assistant (NA) stated Resident #303's cigarettes and lighter were kept locked up at the nursing station; when Resident #303 requested his smoking materials he was provided two cigarettes and a lighter by staff. Staff escorted Resident #303 to the elevator and shut the WanderGuard alarm off on the elevator before Resident #303 exited the floor. No one accompanied Resident #303 to smoke although Resident #303 had to wear a smoking apron for protection. The NA stated that 90 percent of the time Resident #303 smoked in the smoking shack; the NA indicated "people" would have to tell Resident #303 he had to go to the smoking shack to smoke. The NA stated Resident #303 was known to "bum" cigarettes from other Veterans in the smoking shack. The NA stated Resident #303 did not have to return to the floor within a certain time frame after he finished smoking.
- On 12/19/18 at approximately 3:10 p.m., leadership staff was notified of the immediate jeopardy situation related to the observation of Resident #303 not smoking safely and the need to provide an abatement plan to address the immediate jeopardy. During the

meeting, the associate chief nurse (ACN) stated that on 10/31/18 burns were observed in Resident #303's clothing that required Resident #303 to be supervised when smoking. It was indicated that on 11/07/18, the nurse practitioner (NP) determined staff were to provide Resident #303 with one cigarette and his lighter and the Resident #303 could smoke unsupervised as the resident was reportedly "compliant and turning in his lighter upon return."

- On 12/19/18 at 5:20 p.m., CLC leadership staff provided an abatement plan to address the immediate jeopardy situation that was accepted and included:
    - "Identify all high-risk smokers.
    - Re-assess high risk smokers using smoking assessment tool.
    - Effective immediately, smoking veterans who are determined to require supervision via the assessment tool will be unable to smoke unsupervised.
    - Staff education regarding policy.
    - Providers/Psychologists to be educated regarding smoking policy."
    - The mitigation plan for Resident #303 included:
        - "Smoking Reassessment.
        - VA Police notified.
        - Restricted to the unit.
        - Smoking Privileges revoked.
        - Nicotine Replacement.
        - STAR VA treatment plan update.
        - Family meeting to be scheduled on 12/20/18.
        - Modification to the Plan of Care."

Aspiration Precautions

Resident #203, [LOCATION]

- According to records reviewed, Resident #203 was admitted to the CLC with diagnoses including dysphagia, non-Alzheimer's dementia, and anxiety. According to a significant change MDS dated 12/10/18, Resident #203 had clear speech, was usually understood and was able to usually understand others; the resident had short-term and long-term memory problems and moderately impaired cognitive skills for daily decision making based on staff assessment. The MDS was coded to indicate there were no signs or symptoms of a possible swallowing disorder; the resident was to receive a mechanically altered diet. According to the MDS, Resident #203 required limited assistance with eating and had no functional limitations in range of motion of the upper extremities.
- During the initial tour on 12/18/18 at 10:30 a.m., a registered nurse reported that Resident #203 required supervision at meals.
- A 10/03/18 progress note documented that Resident #203 was experiencing a "productive cough of moderate amounts of thick but clear phlegm while having difficulty with PO [oral] intake…does not appear to have concerning symptoms or the start of any respiratory process." The note further documented that the symptoms appeared similar to the last exam. The progress note summarized Resident #203's symptoms as "Recurrent Aspiration w/ [with] high risk for PNA [pneumonia]." At the time of the progress note, a chest x-ray was completed and "not entirely diagnostic of PNA."
- Resident #203 had current provider orders that included:
    - 10/02/18: "Supervision/Assistance with meals: 1:1 [one-to-one] SUPERVISION WITH MEALS [emphasis not added] in patient's room given refusal to leave it [the room] and very elevated aspiration risk; vet [Veteran] also needs set-up assistance (open containers, orient him to items on his tray due to poor vision)…."
    - 10/05/18: "Dysphagia Mech [mechanically] Altered, Nectar Thick Liquids Diet."
- According to a 10/15/18 speech language pathology discharge note, Resident #203 stated to the speech language pathologist, "I cough when I go [eat] too fast, or when they [nursing staff] feed me too fast." According to the note, dysphagia mechanically-altered foods and nectar-thick liquids were recommended, with one-to-one supervision with meals if the resident ate in his room. The following "compensatory strategies" were recommended: "moisten mouth before taking medications/initiating a meal-add extra moisture to food to help compensate for dry mouth-SMALL [emphasis not added] bites/sips, EAT slow, SWALLOW EVERYTHING DOWN BEFORE TAKING ANOTHER BITE/SIP-TAKE EXTRA SWALLOWS/COUGH AS NEEDED TO CLEAR THROAT [emphasis not added], rest breaks as needed[.]" The following "aspiration precautions" were also recommended: "…90 degrees UPRIGHT [emphasis not added] for all intake, OOB [out of bed] when possible-staff to observe/feed patient as needed-discontinue any consistency or meal if patient demonstrates overt signs of aspiration, including recurrent coughing, throat clearing, wet vocal quality, shortness of breath, increased respiratory rate, facial redness, oxygen saturation < [less than] 90% etc[.]"
- Resident #203's plan of care dated 12/13/18 addressed the resident's aspiration risk under nutrition/weight loss. The goal read, "I will maintain my current weight within the

next 90 days." Approaches included "Please allow me extra time to eat if needed [and] Please offer frequent nectar thick fluids although I may refuse. I prefer thin liquids." The plan did not include Resident #203's recommended compensatory strategies or (other) aspiration precautions.

- On 12/19/18 at 12:35 p.m., the dietitian stated Resident #203 was initially receiving a pureed diet in October (2018), when the resident's dysphagia "progressed," however, the resident was not eating and was losing weight. The speech language pathologist and the resident's power of attorney discussed the resident's quality of life and risk for aspiration pneumonia and decided a mechanically altered diet was appropriate; as a result, Resident #203's diet was upgraded at that time [10/05/18 provider order]."
- On 12/20/18 at 9:05 a.m., the speech language pathologist who evaluated Resident #203's swallowing function and recommended the diet and swallowing precautions on 10/15/18, stated Resident #203 had a history of sounding like the resident was having difficulties at meals (coughing and displaying a wet vocal quality); however, the resident has had no aspiration pneumonia. The speech language pathologist reported the resident would likely be safest with a pureed diet; however, based on a family member's and the resident's requests, the resident was to receive a mechanically altered diet. According to the speech language pathologist, the resident tolerated the diet when she observed the resident on 10/15/18. The speech language pathologist reported that staff should provide direct supervision if the resident ate in his room and observation when the resident ate outside his room. The speech language pathologist confirmed the resident was to take small bites and sips and should clear his mouth and swallow food or liquid before taking another bite or sip; Resident #203 should stop eating if the resident began repeatedly coughing.
- On 12/20/18 at 9:20 a.m., a different nursing assistant than the nursing assistant helping the resident with the meal on 12/18/18 (as indicated below) and who regularly provided care for Resident #203 stated the resident fed himself after the nursing assistant provided set up assistance at meals. The nursing assistant reported Resident #203 was to be supervised (one-to-one) if eating in his room; otherwise, the resident ate in the solarium (where nursing staff were present). When asked what Resident #203's aspiration precautions were, the nursing assistant stated the resident had an order for thickened liquids and was to be out of bed while eating.
- On 12/18/18 at 5:00 p.m., Resident #203 was observed eating independently in the solarium (the small dining room for residents who require supervision while eating). Nursing staff were present in the solarium during the meal observation from 5:00 to 5:45 p.m. The resident was observed eating independently (from 5:00 to 5:20 p.m.) taking very small bites of food and small sips of beverages. The dysphagia mechanically altered food items were moist and all beverages were nectar thick. A nursing assistant (NA) sat next to the resident at 5:20 p.m. and began providing eating assistance; the NA gave the resident half teaspoon sized bites of food, waiting for the resident to fully chew and swallow before offering another bite. Intermittently, Resident #203 would feed himself a very small bite of food; the nursing assistant would then give the resident a spoon that was 75% to 100% full of food, prior to the resident finishing what was in the resident's mouth at which point the resident coughed briefly and had a wet vocal quality. The NA gave the resident a spoonful of food prior to the resident finishing what was in the resident's mouth three times during the observation. The nursing assistant paused while the resident coughed briefly and once the resident stopped coughing, the nursing assistant gave the resident another bite of food from a spoon that was 75% to 100% full. Resident #203 would chew the food thoroughly; prior to fully swallowing the food, the nursing assistant would offer the resident another bite; however, Resident #203 shook his head no to indicate he was not ready for another bite. When the resident fully swallowed the food, the resident accepted another bite of food. Throughout the meal, while the nursing assistant was providing eating assistance for Resident #203, the resident briefly coughed intermittently and displayed a wet vocal quality. During the meal observation, the nursing assistant did not wait until the resident swallowed everything that was in his mouth before offering another bite of food and did not offer small bites in accordance with speech language pathology recommendations.

Resident #403, [LOCATION]

- Resident #403 was admitted to the CLC with diagnoses including Alzheimer's disease and dementia. The resident's most current quarterly Minimum Data Set (MDS) dated 10/12/18 indicated the resident had moderately impaired vision, spoke a language other than English, and had severely impaired cognitive skills for daily decision making and short-term and long-term memory problems based on staff assessment. The quarterly MDS indicated the resident required supervision with eating, and did not have signs or symptoms of a swallowing disorder. The resident had no functional limitations in range of motion of the upper or lower extremities. The quarterly MDS dated 10/12/18 indicated the resident's weight was 187 pounds.
- Resident #403's plan of care dated 07/23/18 stated, "My Concern: Nutrition and Weight Status. My Goals: I want to have adequate intake/hydration and have tolerance to my

diet consistency to maintain my skin integrity and preserve my lean body mass….How Can You Help Me: Continue to offer meal set up as needed."

- A nutritional note dated 11/06/18 stated, "Nutrition Diagnostic Statement (1) Self feeding difficulties related to Alzheimer's disease as evidenced by need for meal set up. Nutrition Intervention: Nutrition Prescription: 1) Continue regular diet). Monitoring and Evaluation: Goals: Adequate intake/hydration (> [greater than] 75%)….Continue to offer meal set up as needed."
- During observations in the dining room in the [LOCATION] neighborhood on 12/18/18 at 4:45 p.m., 14 residents were being served the evening meal. At 5:00 p.m., Resident #403 was served the meal and observed eating without assistance. When the meal was served, food items were uncovered, and the resident's meal was removed from the tray and placed on the table in front of the resident. The resident was served turkey that was in large pieces and cooked vegetables. Staff did not assist the resident to cut up the meat; instead, the resident used his fingers to pick up large chunks of meat and place the meat in his mouth. One piece of turkey was approximately four inches in length by 1.5 inches in width with the turkey skin hanging from the meat; the resident placed all of the meat and skin into his mouth at once. The resident was not observed to cough or choke.

Resident #103, [LOCATION]

- Resident #103 was admitted to the CLC with diagnoses including chronic obstructive pulmonary disease, (COPD), dementia, and Parkinson's disease. The history and physical dated 03/13/18 stated, "In 2012 he [the resident] suffered foreign body aspiration and underwent a bronch [bronchoscopy] with foreign body removal."
- According to the resident's comprehensive MDS dated 01/25/18, the resident had clear speech, usually understood and was usually understood by others and had a Brief Interview for Mental Status (BIMS) score of 11 suggesting moderately impaired cognition. The MDS indicated the resident required supervision and limited assistance with eating; the resident had no functional limitations in range of motion. The quarterly MDS dated 10/14/18 was coded the same for cognitive status, eating assistance and functional limitations as the 01/25/18 MDS.
- The history and physical dated 09/09/18 stated, "Called by nursing as patient is having increased respiratory rate with tachycardia after vomiting. He was in his usual state of health until this morning….SOB [shortness of breath] likely aspiration."
- A readmission note dated [DATE] stated, "Acute or chronic respiratory failure likely secondary to aspiration pneumonia versus mucous plugging."
- On 09/14/18, the speech therapist wrote a note that stated, "Recommend maintain present Dysphagia mechanically altered diet with thin liquids….2. Supervision level – close active supervision with feeding assist[ance] as accepted. Offer hand over hand assist for liquids….4. Assist out of bed for meals. Position upright 90 degrees. Small sips/small bites. Chew food thoroughly. Rest breaks as needed. 5. Precautions - Aspiration Precautions HOB [head of bed] elevated 90 degrees when eating and drinking. Staff observe and feed patient if needed. HOB 30 degrees at all times...."
- The plan of care dated 11/09/18 stated under nutritional status, "I am on a regular diet." The care plan goal stated, "I will not experience choking and/or difficulty with swallow [swallowing] food/fluids." The plan indicated, "Assess for s/s [signs and symptoms of] aspiration, such as dyspnea, cough, cyanosis, wheezing, fever, etc. Continue to offer close supervision and 1:1 [one-to-one] assistance with meals. Monitor and assess for impaired swallowing or aspiration, including coughing, choking, spitting food or excessive drooling. Consult speech/OT [occupational therapist]. Please maintain strict aspiration precautions for recurrent aspiration [including] close active supervision."
- On 12/18/18 at 5:05 p.m., Resident #103 was observed in bed with the head of the bed elevated approximately 45 degrees as confirmed by an RN; a meal tray was in front of the resident on a table. A nursing assistant was standing by the bed and observing the resident while the resident ate. The resident was feeding himself and holding a fork with shredded turkey. The resident ate small bites and chewed the turkey thoroughly. The resident started coughing and the nursing assistant repositioned the resident by raising the head of the bed to approximately 45 degrees. The nursing assistant did not comment on why the head of the bed was not elevated to 90 degrees. The resident had consumed 20% of the meal and stated he was finished with the meal. The nursing assistant removed the meal tray and left the resident alone with a cup of coffee. (The resident was observed drinking coffee that was left at the bedside after each meal. The resident was not observed coughing while drinking the coffee.)
- On 12/19/18 at 8:58 a.m., the resident was observed in bed with the head of the bed elevated approximately 30 degrees; the resident had a cup with handles that contained coffee. The resident was alone and was observed drinking from the cup. The resident was not observed coughing or with other concerns. During an interview on 12/19/18 at approximately 9:30 a.m., with the nursing assistant that assisted the resident with breakfast on 12/19/18 (a different nursing assistant than the nursing assistant observed on 12/18/18) the nursing assistant stated the resident ate all of the breakfast meal and

the nursing assistant left the cup of coffee for the resident because he "likes his coffee." The NA stated the resident preferred to stay in bed; the NA did not comment on why the head of the bed was not elevated 90 degrees.

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483.65 *Infection Control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Some

Based on observation, interview and record review, the CLC did not maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection. Findings include:

Transmission-based Precautions
On 12/19/18 at 10:10 a.m., the chief of quality provided a policy and procedure dated October 26, 2018, and titled, "Transmission Based Isolation Precautions." The policy stated, "Enhanced Barrier Precautions are the Community Living Centers version of Contact Precautions….Requirement for Barrier Precautions: Gloves and Gowns are required for any contact with resident and/or the immediate resident environment. Some examples include passing medications, assisting with activities of daily living, bathing, repositioning, and dressing changes."

On 12/20/18 at 10:20 a.m., the performance management specialist provided a policy dated June 2016 and titled, "Revised Guideline for Implementation of the VHA MRSA [methicillin-resistant *Staphylococcus aureus*] Prevention Initiative in Community Living Centers." Attachment B of the policy, "Rooming for MRSA Colonized or Infected Residents," "Limiting bedroom occupancy to a single resident is preferred for all MRSA colonized or infected residents. If private bedrooms are not available, MRSA colonized and infected residents can be cohorted…under exceptional circumstances and with the advice of local Infection Prevention and Control Professionals…the MRSA negative resident should…Have intact skin with no significant open wounds or breaks in skin…Have no invasive devices such as indwelling vascular devices, urinary catheters, feeding tubes, or drainage devices…not [be] immunocompromised…."

Resident #203, [LOCATION]

- On all three days of the survey, a sign was posted on the door to Resident #203's room indicating, "Enhanced Barrier Isolation." The sign read, "In addition to Standard Precautions - Gown & Gloves for contact with Resident & Immediate Environment - Perform Hand Hygiene Upon Entering & Leaving Room." According to the performance management specialist during the initial tour on the morning of 12/18/18, both staff and the surveyor were expected to follow the instructions as listed on the sign.
- On 12/20/18 at 9:35 a.m., the performance management specialist stated that based on the resident's record, Resident #203 did not have an infection or colonization; the resident's roommate had colonized methicillin-resistant *Staphylococcus aureus* (MRSA) in the nares. The performance management specialist further indicated that staff from infection (prevention and) control stated Resident #203 was able to reside in the same room as the resident's roommate as Resident #203 met the qualifications to be in the room (e.g., intact skin, no invasive devices, not immunocompromised).
- On 12/19/18 at 12:35 p.m., a nursing assistant entered Resident #203's room to assist the resident with using the toilet; the nursing assistant performed hand hygiene and donned gloves but no gown. While the nursing assistant was assisting the resident out of bed, the resident touched the nursing assistant's wrist that was not covered with a glove. Once Resident #203 was standing, the nursing assistant and the resident entered the bathroom in the resident's room and closed the door. The observation ended at this time.

Resident #201, [LOCATION]

- During the initial tour on the morning of 12/18/18 at 11:10 a.m. and 2:30 p.m., there was no signage posted on or near the door to Resident #201's room indicating that transmission-based precautions were to be implemented for the resident. Prior to the initial tour, when speaking with a registered nurse regarding care and services provided for residents in the neighborhood, there was no information provided indicating staff were to implement transmission-based precautions for Resident #201. At 2:30 p.m., a surveyor performed hand hygiene prior to entering the room; sat on Resident #201's bedside chair while interviewing the resident and touched the resident's privacy curtains after the interview was complete; the surveyor performed hand hygiene upon exiting the room.
- On 12/19/18 at approximately 12:40 p.m., the surveyor and performance management specialist observed a transmission-based precautions sign posted on Resident #201's door. Upon further review, the performance management specialist reported the sign had been placed on Resident #201's door by a resource nurse.

- On 12/19/18 at 1:00 p.m., there was no signage posted on or near the door to Resident #201's room indicating that transmission-based precautions were to be implemented for the resident. Another surveyor entered Resident #201's room to observe wound care; the surveyor did not come into contact with the resident or the resident's environment and the observed wound care was performed correctly with appropriate gown and glove usage.
- According to a clinical warning note dated 08/30/18 provided by the performance management specialist on 12/20/18, Resident #201's nasal swab tested positive for MRSA and "enhanced barrier isolation" was to be implemented for the resident.

Resident #106, [LOCATION]

- On 12/19/18 at 9:13 a.m. during medication administration observations, an LPN entered Resident #106's room; a sign was posted on the wall outside the resident's room near the door jamb that indicated, "Enhanced Barrier Isolation." The sign stated, "In addition to Standard Precautions - Gown and Gloves for contact with Resident and Immediate Environment - Perform Hand Hygiene upon Entering and Leaving Room."
- After sanitizing her hands, the LPN entered the room with the Bar Code Medication Administration (BCMA) scanner to scan the resident's identification bracelet. The LPN leaned against the bed with her uniform touching the resident's bed linens. The LPN returned to the medication cart and collected the resident's medications including dorzolamide eye drops.
- The LPN re-entered the room after sanitizing her hands and applying gloves. The resident was in bed and the nurse leaned against the bed with her uniform coming into contact with the bed linen. The nurse administered the eye drops, disposed of her gloves in the trash receptacle and sanitized her hands.
- A nursing assistant was also observed in the resident's room preparing to complete the resident's care; the nursing assistant was not wearing a gown or gloves. During an interview with the LPN and nursing assistant immediately following the eye drop administration, the LPN and nursing assistant stated they were not aware Enhanced Barrier Precautions were to be implemented for the resident; however, they noted the sign and stated they should have been wearing gowns and gloves when providing care for the resident.

Hand Hygiene
On 12/19/18 at 2:45 p.m., the chief of infection control provided the Edith Nourse Rogers Memorial Veterans Hospital Bedford Veterans Affairs Medical Center, Bedford, Massachusetts Policy HM.003.38.PM titled, "Hand Hygiene," and dated May 7, 2018. The policy indicated hands were to be decontaminated or washed before inserting or handling any invasive device for patient care, and before donning gloves and after removing sterile or non-sterile gloves.

On 12/19/18 at 1:45 p.m. the associate director of patient care services provided Elsevier's Clinical Skills titled, "Feeding Tube: Medication Administration." The clinical skills stated, "21. Perform hand hygiene and don gloves….39. Discard supplies, remove gloves, and perform hand hygiene."

Resident #305, [LOCATION]

- On 12/19/18 at 7:56 a.m., the surveyor and performance management specialist observed an RN entering Resident #305's room with supplies for a dressing change for the resident's left foot. Staff were not required to implement transmission-based precautions for the resident. Without performing hand hygiene, the RN moved papers, a glass of water and a magazine on the resident's overbed table; and placed all the sealed packages of dressings directly on Resident #305's overbed table without first placing a barrier or disinfecting the surface. The RN donned gloves, raised Resident #305's bed, placed a barrier under Resident #305's left foot and moved the bag bath packet onto the bedspread. The RN removed the dressing from Resident #305's left foot, placed the soiled dressing in the trash receptacle, doffed gloves, obtained another pair of gloves from the box and donned the gloves without first performing hand hygiene.
- The RN opened packages of 2-inch by 2-inch (2X2) gauze pads, obtained a bottle of Betadine from the wall cupboard, positioned Resident #305's sheet/blanket under his left leg, cleansed the bottom of Resident #305's left foot with a 2X2 gauze pad and Betadine, and placed the gauze on the wrapper from a dressing on the overbed table. The RN obtained another 2X2 gauze pad, applied Betadine and used the gauze to cleanse between each of Resident #305's toes on his left foot. The RN opened a Mepilex® dressing package and retrieved the dressing, removed a magic marker from his right uniform pocket, dated and initialed the Mepilex dressing, returned the magic marker to the RN's right uniform pocket and applied the Mepilex dressing to the ball of Resident #305's left foot. The RN opened 3 packages of gauze dressings and applied gauze pads between each of Resident #305's toes. The RN opened a Kerlix™ dressing and ABD pads, applied an ABD pad to Resident #305's left heel and the

bottom of the resident's foot. The RN wrapped Resident #305's left foot with the Kerlix dressing, obtained a roll of tape from the wall cabinet, used 2 pieces of tape to secure the dressing, and doffed the right glove.

- Without performing hand hygiene or removing the right glove, the RN removed the magic marker from his right uniform pocket, dated and initialed the dressing, and replaced the magic marker in his right uniform pocket. The RN placed the roll of tape and bottle of Betadine into the wall cabinet, lowered Resident #305's bed, picked up the opened wrappers from the overbed table with his left gloved hand, placed a sealed package with gauze into the wall cabinet using his right hand, disposed of the wrappers in the trash receptacle, doffed the left glove and performed hand hygiene prior to exiting the room. The RN did not sanitize the overbed table prior to exiting the room.

Resident #306, [LOCATION]

- On 12/19/18 at 8:12 a.m., a surveyor and performance management specialist observed an LPN administering six medications through Resident #306's PEG tube.
- The LPN donned gloves without first performing hand hygiene and prepared the resident's medication, entered Resident #306's room, and placed the medicine cups, sterile water bottle and syringe on the overbed table without first placing a barrier. The LPN doffed gloves and without performing hand hygiene, assisted Resident #306 to reposition in bed, raised the head of the bed using the controls located on the foot of the bed, and uncovered and touched the resident's PEG tube. The LPN opened the room door, exited the room and performed hand hygiene with sanitizer in the hall.
- Without donning gloves, the LPN re-entered the resident's room, and administered Resident #306's medications through the PEG tube. After administering five medications, the LPN positioned Resident #306's PEG tube under his gown, and covered Resident #306 with the sheet and blanket. Without performing hand hygiene, the LPN donned a pair of gloves. The LPN moved the overbed table to the side of the bed, lowered the bed, moved the floor mat closer to the side of the bed, adjusted Resident #306's pillow behind his head, doffed the gloves and performed hand hygiene.
- The LPN observed a crushed medication in a plastic medication cup on Resident #306's overbed table and exited the room with the crushed medication to obtain another syringe.
- At 8:39 a.m., the LPN returned to Resident #306's room with the syringe and crushed medication and performed hand hygiene. The LPN added 5 ml of water to the crushed medication, donned a glove on her right hand, removed the emesis basin from the bedding near Resident #306, doffed the right glove and performed hand hygiene.
- Without donning gloves, the LPN administered the crushed medication through the resident's PEG tube. After administering the medication, the LPN donned gloves without first performing hand hygiene. The LPN lifted Resident #306's left arm, placed the PEG tube under Resident #306's gown, covered Resident #306 with a sheet and blanket, gave Resident #306 an emesis basin, and doffed gloves.
- The LPN discarded the syringe and medication cup in the trash receptacle, dropped a folded paper on the floor, picked the paper up from the floor with a bare hand, placed the folded paper in her left uniform pocket, and performed hand hygiene prior to exiting the room.